Republic of the Philippines
Department of Finance
INSURANCE COMMISSION
1071 United Nations Avenue
Manila

CN: AJA16-0061

ADVISORY No. 6-2017

TO : **ALL HEALTH MAINTENANCE ORGANIZATIONS (HMOs) DOING BUSINESS IN THE PHILIPPINES**

SUBJECT : **INVENTORY OF HMO PRODUCTS**

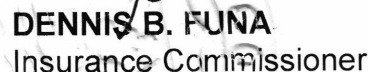
DATE : **MAY 3, 2017**

Pursuant to the issuance of Circular Letter No. 2017-19 **Guidelines on the Approval of HMO Products and Forms**, all HMOs are hereby directed to make an inventory of **all** HMO products that the company is currently selling as well as products that the company has sold and continues to have an obligation since the period of coverage has not yet expired (even if the company has stopped selling the product).

The company shall provide the complete details **per product** by accomplishing the Product Inventory Report (see **Annex A**), duly certified by an officer with a rank of at least Vice President.

The report shall be submitted to the Actuarial Division **not later than June 30, 2017.**

For strict compliance.



DENNIS B. FUNA
Insurance Commissioner

ANNEX A

PRODUCT INVENTORY REPORT

Name of Company: ______________________________

Note: Indicate "INACTIVE" under Remarks Column if the product is no longer being sold but the term of agreement issued has not yet expired. Please attach **extra sheet** if needed.

NAME OF PRODUCT (Specify the marketing Name, if any)	TYPE OF PRODUCT	PERIOD OF COVERAGE	MEMBERSHIP FEE PAYMENT PERIOD	PAYMENT OPTION	BENEFITS	SPECIAL PRODUCT FEATURES / OTHER BENEFITS PROVIDED BY HMO (please specify)	PRODUCT BUNDLING (BENEFITS PROVIDED BY NON-HMO)	Remarks
<Product No. 1>	☐ Individual/Family ☐ Group/Corporate	☐ Less than 12 months ☐ 12 months ☐ More than 12 months Specify:____years	☐ Up to 12 months ☐ Guaranteed ☐ Non-Guaranteed ☐ 12 months ☐ Guaranteed ☐ Non-Guaranteed ☐ More than 12 months Specify: ___years ☐ Guaranteed ☐ Non-Guaranteed	☐ Pre-agreed membership fee ☐ Fund Under Administrative Services Only (ASO) or Third Party Agreement (TPA) * If combination of the two, check both	☐ In-Patient ☐ Out-patient ☐ Emergency Care benefit ☐ Annual Physical Exam ☐ Executive Check-up ☐ Dental Benefit ☐ Maternity Benefit Others: (Please specify) ____________ ____________	(e.g. Return of Premium, burial benefit, accidental death benefit, disability benefit, etc.)	☐ With Insurance Product Name of Product: ________ Name of Insurance Company: ____________ ☐ With Pre-Need Benefit Name of Product: ________ Name of Pre-Need Company: ____________ ☐ Other additional benefit: (Please specify)	
<Product No. 2>	☐ Individual/Family ☐ Group/Corporate	☐ Less than 12 months ☐ 12 months ☐ More than 12 months Specify:____years	☐ Up to 12 months ☐ Guaranteed ☐ Non-Guaranteed ☐ 12 months ☐ Guaranteed ☐ Non-Guaranteed ☐ More than 12 months Specify: ___years ☐ Guaranteed ☐ Non-Guaranteed	☐ Pre-agreed membership fee ☐ Fund Under Administrative Services Only (ASO) or Third Party Agreement (TPA) * If combination of the two, check both	☐ In-Patient ☐ Out-patient ☐ Emergency Care benefit ☐ Annual Physical Exam ☐ Executive Check-up ☐ Dental Benefit ☐ Maternity Benefit Others: (Please specify) ____________ ____________	(e.g. Return of Premium, burial benefit, accidental death benefit, disability benefit, etc.)	☐ With Insurance Product Name of Product: ________ Name of Insurance Company: ____________ ☐ With Pre-Need Benefit Name of Product: ________ Name of Pre-Need Company: ____________ ☐ Other additional benefit: (Please specify)	

Prepared by:

____
Signature over Printed Name
<Position>
E-mail address:
Contact Number:

Certified Correct by:

____
Signature over Printed Name
<Position>